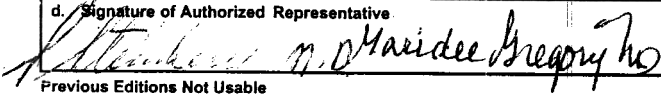


APPLICATION FOR FEDERAL ASSISTANCE

OMB Approval No. 0348-0043

1. TYPE OF SUBMISSION: Application <input type="checkbox"/> Construction Preapplication <input type="checkbox"/> Construction <input checked="" type="checkbox"/> Non-Construction <input type="checkbox"/> Non-Construction		2. DATE SUBMITTED 07/14/2003	Applicant Identifier
		3. DATE RECEIVED BY STATE	State Application Identifier
		4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier
5. APPLICANT INFORMATION			
Legal Name: State of California		Organizational Unit: Title V Agency: MCH Branch/CMS Branch	
Address (give city, county, state, and zip code): Department of Health Services 1615 Capitol Avenue, 5th Floor P.O. Box 942732 MS 8305 Sacramento, CA 94234-7320		Name and telephone number of the person to be contacted on matters involving this application (give area code) MCH: Susann J. Steinberg, M.D. (916) 657-1347 CMS: Maridee Gregory, M.D. (916) 327-3287	
6. EMPLOYER IDENTIFICATION NUMBER (EIN): 68 - 0317191		7. TYPE OF APPLICANT: (enter appropriate letter in box) <input type="checkbox"/>	
8. TYPE OF APPLICATION: <input checked="" type="checkbox"/> New <input type="checkbox"/> Continuation <input type="checkbox"/> Revision If Revision, enter appropriate letter(s) in box(es): <input type="checkbox"/> <input type="checkbox"/> A. Increase Award B. Decrease Award C. Increase Duration D. Decrease Duration Other (specify):		A. State H. Independent School Dist. B. County I. State Controlled Institution of Higher Learning C. Municipal J. Private University D. Township K. Indian Tribe E. Interstate L. Individual F. Intermunicipal M. Profit Organization G. Special District N. Other (Specify):	
10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: 93 - 994 TITLE: Maternal & Child Health Services Block Grant		9. NAME OF FEDERAL AGENCY: Health Resources & Services Administration MCHB	
12. AREAS AFFECTED BY PROJECT (cities, counties, states, etc.): State of California		11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT: Title V Block Grant Agency State of California Department of Health Services Maternal and Child Health Branch and Children's Medical Services Branch	
13. PROPOSED PROJECT: Start Date Ending Date 10/01/2003 09/30/2004		14. CONGRESSIONAL DISTRICTS OF: a. Applicant: All California Districts (current 1-45) b. Project: Same as 14a	
15. ESTIMATED FUNDING:		16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?	
a. Federal	\$ 44,341,423.00	a. YES. THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON:	
b. Applicant	\$ 2,600,000.00	DATE _____	
c. State	\$ 849,821,442.00	b. NO. <input checked="" type="checkbox"/> PROGRAM IS NOT COVERED BY E.O. 12372	
d. Local	\$.00	<input type="checkbox"/> OR PROGRAM HAS NOT BEEN SELECTED STATE FOR REVIEW	
e. Other	\$.00		
f. Program Income	\$ 702,871,553.00		
g. TOTAL	\$ 1,599,634,418.00	17. IS APPLICATION DELINQUENT ON ANY FEDERAL DEBT? <input type="checkbox"/> YES If "Yes," attach an explanation. <input checked="" type="checkbox"/> No	
18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT, THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.			
a. Typed Name of Authorized Representative Susann J. Steinberg, M.D.; Maridee Gregory, M.D.		b. Title Acting Chief, MCH Br., Chief, CMS Br.	c. Telephone number (916) 657-1347
d. Signature of Authorized Representative 		e. Date Signed 7/9/03	

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Standard Form 424 (Rev. 7-97)
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